Registration Worksheet (RW)

Visit: Baseline

Patient ID: ☐☐☐☐☐☐

Patient Initials: ☐☐☐ *F M L*

Institution No: _____

Institution Name: _____

Registration Date: _____ *mm dd y y y y*

Registration Web Site Address: http://www.acosog.org

Has patient previously been registered to an ACOSOG study?

☐ Yes → Coordinating Group Protocol Number: _____

☐ No

Patient Information

Date of Birth: _____ *mm dd y y y y*

Gender: ☒ Female

Race: *(Mark all that apply)*

☐ White
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ Asian
☐ American Indian or Alaska native
☐ Unknown

Ethnicity: *(Mark only one)*

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Weight: ☐☐☐.☐☐ kg

Height: ☐☐☐.☐ cm

Method of Payment *(Mark all that apply):*

☐ Private insurance
☐ Medicare
☐ Medicare and private insurance
☐ Medicaid
☐ Medicaid and Medicare
☐ Military or veterans sponsored NOS
☐ Military sponsored *(including CHAMPUS and TRICARE)*
☐ Veterans sponsored
☐ Self pay *(no insurance)*
☐ No means of payment *(no insurance)*
☐ Other, specify: _____
(e.g., Provincial Insurance Plan)

Patient Zip Code (USA): _____ – _____ **OR** Postal Code (Canada): _____ _____

Other Country Postal Code: _____ Country of Residence: _____
(If other than USA or Canada)